STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/24/2020. Corrections are required for compliance with 42 CFR Part 483.73, 483.75, Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000	See attached written POC.	
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane M Sellers, Dir, OOOP | TITLE | (X6) DATE: Sept 16, 2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure an emergency preparedness plan was documented for the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding an annual review of the facility's EP plan. The Administrator stated, "There hasn't been any changes. Do I need to review annually? An annual review has not been done." No further information was provided prior to exit on 08/24/2020.	E 004		
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented,	E 006		

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E 006	Continued From page 2 facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		

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E 006	Continued From page 3 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure a risk assessment was included in the emergency preparedness plan for the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding the facility's risk assessment. The Administrator stated, "A facility risk assessment has not been done, because it would be part of the annual review." No further information was provided prior to exit on 08/24/2020.	E 006		
E 009	Local, State, Tribal Collaboration Process CFR(s): 483.475(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years (annually for LTC facilities). The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a	E 009		

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E 009	Continued From page 4 disaster or emergency situation. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure the emergency preparedness plan included the facility's efforts to contact Emergency officials for participation in a collaborative and cooperative planning effort for the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding the facility's efforts to contact Emergency officials for collaborative and cooperative planning efforts. The Administrator stated, "No, it would have been done with the annual update." No further information was provided prior to exit on 08/24/2020.	E 009		
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must	E 013		

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E 013	Continued From page 5 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure the specific emergency preparedness policies or facility risk assessment was located and available in the facility. Findings include:	E 013		

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E 013	Continued From page 6 During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding an annual review of policies and procedures. The Administrator stated, "No, it would have been done with the annual update." No further information was provided prior to exit on 08/24/2020.	E 013		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 483.475(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.	E 024		

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E 024	Continued From page 7 *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure specific emergency preparedness policies for staffing or use of volunteers were located and available in the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding policies and procedures for use of volunteers. The Administrator stated, "I'm pretty sure it is in there somewhere, but I can't find it." No further information was provided prior to exit on 08/24/2020.	E 024		
E 026	Roles Under a Waiver Declared by Secretary CFR(s): 483.475(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years	E 026		

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E 026	Continued From page 8 (annually for LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure an emergency preparedness policy regarding care of individuals residing in the facility under the 1135 waiver. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding policies and procedures on the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The Administrator stated, "I'm not sure that is in there." No further information was provided prior to exit on 08/24/2020.	E 026		
E 029	Development of Communication Plan CFR(s): 483.475(c)	E 029		

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E 029	Continued From page 9 (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC). This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure the emergency preparedness communication plan had been reviewed annually, in the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding an annual review of the communication plan. The Administrator stated, "No, hasn't been done." No further information was provided prior to exit on 08/24/2020.	E 029		
E 030	Names and Contact Information CFR(s): 483.475(c)(1) [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E 030		

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E 030	Continued From page 10 (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.	E 030		

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E 030	Continued From page 11 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure facility contact information had been updated and reviewed in the emergency preparedness plan for the facility. Findings include:	E 030		

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E 030	Continued From page 12 During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding Facility contact information. The Administrator stated, "Nothing has been updated because the annual review hasn't been done." No further information was provided prior to exit on 08/24/2020.	E 030		
E 031	Emergency Officials Contact Information CFR(s): 483.475(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact	E 031		

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E 031	Continued From page 13 information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure a list of emergency officials was located and available in the emergency preparedness plan for the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding Emergency Officials contact information. The Administrator stated, "Nothing has been updated because the annual review hasn't been done." No further information was provided prior to exit on 08/24/2020.	E 031		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility]	E 039		

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HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 14 must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least	E 039		

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E 039	Continued From page 15 annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual	E 039		

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E 039	Continued From page 16 facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 17 (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E 039		

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E 039	Continued From page 18 (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires	E 039		

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E 039	Continued From page 19 activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (I) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise	E 039		

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E 039	Continued From page 20 following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to ensure documentation regarding the facility's efforts to contact emergency officials for participation in a collaborative and cooperative planning effort for the facility. Findings include: During the unannounced survey conducted 08/24/2020 the facility Emergency Preparedness (EP) process was reviewed with the Administrator. The Administrator was interviewed at approximately 2:30 p.m. regarding an annual tabletop and full scale exercise. The Administrator stated, "We did a plan for Covid-19, but I don't know where it is at. I believe (Surveyor Name) has a copy from the phone infection control interview." No further information was provided prior to exit on 08/24/2020.	E 039		
W 000	INITIAL COMMENTS An unannounced Focused Fundamental Medicaid recertification survey was conducted 08/24/20. The facility was not in compliance with 42 CFR Part 483 Requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The Life Safety Code survey/report will follow. No complaints were investigated during the survey.	W 000		

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W 000	Continued From page 21 The census in this 15 certified bed facility was 14 at the time of the survey. The survey sample consisted of 3 Individual reviews (Individuals #1 through 3).	W 000		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to develop specific objectives in the Individual Support Plan (ISP) for use of a wheelchair with bilateral shoe holders, and a seatbelt for one of three Individuals in the survey sample, Individual #2. Findings include: Individual #2 was admitted in 2004 with diagnoses including, but not limited to cerebral palsy, seizure disorder, and severe intellectual disability. During the review of Emergency Room (ER) visits and hospital admissions for the past year, Individual #2 had a visit to the ER on 12/24/2019 after falling out of his wheelchair. An investigation was conducted by the facility and it was determined there was enough evidence to confirm neglect. Interviews with the two DSP's	W 227		

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W 227	Continued From page 22 (direct service personnel) providing care for Individual #2 was included in the investigation. Both DSP's stated they thought the other person had buckled his bilateral foot straps and seatbelt on his personal wheelchair. Review of Individual #2's ISP (Individual Support Plan) did not include any actions or supports for use of his wheelchair with bilateral foot holders and a seatbelt, except "...I will use my wheelchair...I will cooperate with my support partners and allow them to use a Vanderlift and sling to be placed into my wheelchair..." The Nursing Care Plan was also reviewed and did not include any actions or goals for the use of Individual #2's wheelchair. The Administrator was interviewed at approximately 3:10 p.m., and stated, "Yes, the ISP is considered the active treatment plan." Regarding specific actions and supports for use of Individual #2's wheelchair with bilateral foot holders with security straps and a lap seatbelt, the Administrator stated, "It probably should be part of the ISP, but I can't remember if it is." The Administrator stated at approximately 4:15 p.m., regarding use of Individual #2's wheelchair with foot holders with security straps and a lap seatbelt, "Yes, it should be spelled out in his treatment plan." No further information was received prior to the exit conference.	W 227		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1)	W 368		

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W 368	Continued From page 23 The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based facility document review, clinical record review and staff interview the facility staff failed to administer medications per physician's order for a bowel protocol for one of three individuals in the survey sample, Individual #1. Findings include: Individual #1 was admitted to the facility on 08/09/19. Diagnoses included, but were not limited to: anemia, PICA, increased lips and severe intellectual disability. A review of the facility's systems to prevent abuse, neglect, mistreatment, and resolve complaints was conducted on 08/24/20. During this review, an incident for Individual #1 dated 10/09/19 identified that the individual did not have a bowel movement for the previous 8 days and the physician ordered bowel protocol was not implemented or administered. The bowel protocol order was to, "Check bowel movement: Check and record bowel movement each shift. Give phosphate enema every 48 hours if no BM in 2 days." The individual also had an order for, "Fleet Enema Give 1 rectally as needed every 48 hours in no BM in 2 days...Phosphate enema Use 1 dose as needed every 48 hours if no Bowel Movement in 2 days..." The MARs (medication administration records) were reviewed for October 2019 and revealed that the individual did not have a BM for 7 days	W 368		

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W 368	Continued From page 24 and the bowel protocol orders were not implemented/administered until the 8th day. The director was interviewed on 08/24/20 regarding the above information. The director stated that the staff at the day program were not documenting the resident had a BM. The director was made aware that it was documented that the individual did not have a BM at all, according to the documentation. The director stated that the individual had a BM. The individual's clinical records did not evidence that the individual had a bowel movement during the time period in question. No further information and/or documentation was presented prior to the exit conference to evidence that facility staff followed the physician ordered bowel protocol for Individual #1.	W 368		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to investigate problems identified with evacuation drills for one of three individuals, Individual #3; and failed to investigate problems identified with evacuation drills for individuals who were on isolation [quarantine] for COVID-19 after returning from the hospital. Findings include:	W 448		

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W 448	Continued From page 25 Individual #3 was admitted to the facility originally on 02/04/95. Diagnoses for Individual #3 included, but were not limited to: cerebral atrophy, fetal alcohol syndrome, vision defects, osteoporosis, osteopenia, and severe intellectual disability. On 08/124/20 at approximately 11:00 AM a review of the facility's evacuation drills was conducted. Evacuation drills were reviewed from August 2019 through present (August 2020). The review revealed the following: An evacuation drill dated 08/29/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...Comments...everyone was calm but everything was done quickly as possible...specific problems encountered and corrective actions taken: none...signature of director." An evacuation drill dated 09/14/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of director...[There were no comments listed and no specific problems encountered or corrective actions documented]...signature of director." An evacuation drill dated 11/16/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of director...[There were no comments listed and no specific problems encountered or corrective actions documented]...signature of director." An evacuation drill dated 12/21/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of director...[There were no comments listed and no specific problems	W 448		

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W 448	Continued From page 26 encountered or corrective actions documented]...signature of director." An evacuation drill dated 01/14/19 documented, "...[name of Individual #3]...7 [Initial Refusal the cooperation]...comments...staff went into immediate action and cooperated to get all individuals to safety...specific problems encountered and corrective actions taken: n/a [not applicable]...signature of director." An evacuation drill dated 02/18/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...comments...good cooperation from residents and staff...specific problems encountered and corrective actions taken: n/a [not applicable]...signature of director." An evacuation drill dated 05/27/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of program coordinator." There were no comments and there were no problems or corrective action listed. An evacuation drill dated 06/16/20 again documented that Individual #3 refused to leave the building, it was also documented on this evacuation drill that two individuals who were recently readmitted to the facility from the hospital [who were on a 14 day isolation/quarantine due to COVID-19] were not evacuated from the building. This evacuation drill was signed by the director; there were no comments, specific problems listed, or corrective action plan documented. On 08/18/20 at approximately 11:45 AM, the program coordinator was asked if there was any additional information related to the evacuation drills. The program manager stated that there	W 448		

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W 448	Continued From page 27	W 448		

was not. A policy for evacuation drills was requested at that time.

The policy was presented [Emergency Preparedness and response plan] documented, "...ensure safety of each individual...staff will be trained upon hiring and annually...each location has a plan and shall implement...evacuation system for individuals...fire drills with evacuation must be held monthly on rotating shifts, recorded and filed...do not leave individuals unsupervised..."

On 08/18/20 at approximately 2:40 AM, the director was interviewed and asked who is responsible for reviewing the evacuation drills. The director stated, "The program coordinator."

At approximately 3:00 PM, the director, program coordinator and administrative assistant were interviewed and asked who is responsible for reviewing the evacuation drills. The program coordinator stated, "The director and/or myself."

The program coordinator stated that they review and sign off on the evacuation drills and if there are any problems they will look at those, review with staff and look at what needs to be fixed, and look at our policies.

The facility staff were then asked if an investigation had been completed for any of the identified problems with the above evacuation drills. The facility staff (director, program coordinator and administrative assistant) all agreed that no documented investigations were completed for the issues with the evacuation drills.

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W 448	Continued From page 28 No further information and/or documentation was presented to evidence that any of the identified problems with the evacuation drills were investigated in an attempt to resolve the concerns.	W 448		
W 449	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills and take corrective action. This STANDARD is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to develop and implement corrective action plans for identified problems with evacuation drills for one of three individuals, Individual #3; and two individuals who were on isolation [quarantine] for COVID-19 after returning from the hospital. Findings include: Individual #3 was admitted to the facility originally on 02/04/95. Diagnoses for Individual #3 included, but were not limited to: cerebral atrophy, fetal alcohol syndrome, vision defects, osteoporosis, osteopenia, and severe intellectual disability. On 08/124/20 at approximately 11:00 AM a review of the facility's evacuation drills was conducted. Evacuation drills were reviewed from August 2019 through present (August 2020). The review revealed the following: An evacuation drill dated 08/29/19 documented,	W 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

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W 449	Continued From page 29 "...[name of Individual #3]...8 [Refusal to leave building]...Comments...everyone was calm but everything was done quickly as possible...specific problems encountered and corrective actions taken: none...signature of director." An evacuation drill dated 09/14/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of director." There were no comments listed and no specific problems encountered or corrective actions documented. An evacuation drill dated 11/16/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of director." There were no comments listed and no specific problems encountered or corrective actions documented. An evacuation drill dated 12/21/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...signature of director." There were no comments listed and no specific problems encountered or corrective actions documented. An evacuation drill dated 01/14/19 documented, "...[name of Individual #3]...7 [Initial Refusal the cooperation]...comments...staff went into immediate action and cooperated to get all individuals to safety...specific problems encountered and corrective actions taken: n/a [not applicable]...signature of director." An evacuation drill dated 02/18/19 documented, "...[name of Individual #3]...8 [Refusal to leave building]...comments...good cooperation from residents and staff...specific problems encountered and corrective actions taken: n/a [not applicable]...signature of director."	W 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49G017	A. BUILDING _____ B. WING _____	08/24/2020

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HARRISON ICF-MR	1631 VIRGINIA AVENUE HARRISONBURG, VA 22802

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W 449	Continued From page 30 An evacuation drill dated 05/27/19 documented, "...[name of individual #3]...8 [Refusal to leave building]...signature of program coordinator." There were no comments and there were no problems or corrective action listed. An evacuation drill dated 06/16/20 again documented that individual #3 refused to leave the building. It was also documented on this evacuation drill that two individuals who were recently readmitted to the facility from the hospital [who were on a 14 day isolation/quarantine due to COVID-19] were not evacuated from the building. This evacuation drill was signed by the director; there were no comments, specific problems listed, or corrective action plan documented. On 08/18/20 at approximately 11:45 AM, the program coordinator was asked if there was any additional information related to the evacuation drills. The program manager stated that there was not. A policy for evacuation drills was requested at that time. The policy was presented [Emergency Preparedness and response plan] documented, "...ensure safety of each individual...staff will be trained upon hiring and annually...each location has a plan and shall implement...evacuation system for individuals...fire drills with evacuation must be held monthly on rotating shifts, recorded and filed...do not leave individuals unsupervised..." On 08/18/20 at approximately 2:40 AM, the director was interviewed and asked who is responsible for reviewing the evacuation drills. The director stated, "The program coordinator."	W 449		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 449	Continued From page 31 At approximately 3:00 PM, the director, program coordinator and administrative assistant were interviewed and asked who is responsible for reviewing the evacuation drills. The program coordinator stated, "The director and/or myself." The program coordinator stated that they (herself or the director) review and sign off on the evacuation drills and if there are any problems they will look at those, review with staff and look at what needs to be fixed, and look at our policies. The facility staff were then asked if an investigation had been completed for the identified problems with the evacuation drills. The facility staff all agreed that there was not a documented investigation for any of the issues with the evacuation drills. The administrative assistant stated that with the two individuals on quarantine that was because of the corona virus and they (the facility) really didn't know what to do and stated that they (the facility) felt it was safer for them to remain in the facility and stay in quarantine during that evacuation drill. No further information and/or documentation was presented to evidence that any type of corrective action plan had been developed and/or implemented for the identified problems with the evacuation drills.	W 449		

Harrison ICF-IID

W Tags

W 227

1. To prevent further injury for Individual #2, his annual plan, as well as the MARS, will be revised to include the need for all safety supports for his wheelchair to be documented as being completed as ordered. There will also be a reminder to check each strap, etc., to ensure they are safely secured posted on his closet door in his room. Data will be collected and recorded daily on each shift for compliance with his wheelchair safety guidelines.
   The individual's wheelchair safety plan will be added to his annual plan (ISP), as well as any other safety precautions necessary for the use of adaptive equipment required for his care, including Vanderlifts for transfers, mechanical bed, and bedrails. These will also be added to his nursing care plan. His use of these devices will also have a physician's orders on record, and will be reviewed on at least a quarterly basis during his Interdisciplinary Team meetings.
2. The facility will identify other individuals residing within the residence who have or require the use of adaptive equipment, will have usage and safety data collected in the same manner, with physician's orders for each piece of equipment and safety precautions and proper usage of each listed on the individual's nursing care plan and his/her Individual Service Plan (ISP). Data will be collected daily or as appropriate for the outcomes describing the use of said equipment. In addition, all Direct Support Professionals (DSPs) will be trained in the correct usage of all adaptive equipment by the Program Coordinator or the residential LPN, using hands on demonstrations and instruction and /or videos as appropriate. This training will be completed during the Orientation period for new employees, and will be reviewed at least annually thereafter. Documentation of these trainings will be maintained in the agency's Human Resources offices within the individual's personnel files.
3. Continued compliance will be sustained through regular (quarterly reviews of each individual's nursing care plan and ISP via his/her quarterly Interdisciplinary review. The Program Coordinator and the residential LPN will do random checks with the DSPs to ensure that correct procedures are being followed.
4. Continued compliance will be monitored closely by the Program Coordinator and the Program Director through the use of collected data and observations. Information on staff compliance with the practices and protocols will be maintained in the personnel records.
5. Completion date: 10-4-2020

W 368

1. For individual #1, the Program Coordinator implemented developed a flow chart to be used daily by the Day Support Services personnel to ensure that any and all necessary medical information is reported back to the facility each day upon returning from activities and recorded in the MARS and other appropriate logs or checklists. The nurse or designated

medication staff of the day will be responsible for doing this. Further, the nurse or designated medication staff will be responsible for carefully reading the specific orders on the MARS (as ordered by the individual's physician) and ensuring that the orders are very closely followed. Additionally, the DSPs or nurse in charge of medications for each medication pass each day will be responsible for ensuring the orders are followed as well.

2. The Program Coordinator will identify for every DSP the names of all individuals who have routine bowel orders and ensure that the routine is included in each individual's Individualized Service Plan (ISP), and that the data that is collected daily, and recorded in all appropriate places, including the MARs, the service plan, and the PRN notes. The DSPs will also ensure that any bowel movements that occur off-site (either Day Support or while in the community) are also recorded in the appropriate places at the facility. The LPN or med person on each shift will be responsible for ensuring that the bowel routine data is entered into the MARs, and that the orders are checked for any necessary intervention. The same protocols will be followed for each individual with a physician-identified need.
3. The facility nurse and the Program Coordinator will complete a daily check of the MARs and Bowel checklists to ensure that all necessary data has been collected, and that no required treatments were missed. Corrections will be made immediately as may be needed.
4. On-going monitoring will take place by the Program Coordinator and/or the Program Director to ensure that all corrections and improvements are sustained, and that the solutions set into place are effective. If need be, the changes can be re-evaluated to determine if changes are necessary; if so, new protocols will be developed and implemented immediately.
5. Completion date: 10-1-2020

W 448

1. The current training outcome for Individual #3 was found to not be adequate or effective. A new training plan and evacuation procedures will be developed for this individual. There will also be more in-depth data collected regarding his difficulties with fire and other evacuation drills, and this data will be analyzed quarterly, along with notes on the facility's fire drill forms, by the Program Coordinator and the Program Director for efficacy. If necessary, the steps of the training will be revised as needed.
   Additionally, during a recent fire drill, two individuals who had recently returned from hospitalization and were under quarantine were not evacuated during a fire drill. In the future, the evacuation policy will include all individuals within the facility, regardless of his/her medical status, by use of an alternate exit as appropriate.
2. In order to ensure that all individuals residing within the program are afforded the necessary training and supports to be able to participate in evacuations in true emergency situations. Individuals who need training will be identified by using information gathered through observations, review of past evacuation drills, and each individual's Comprehensive Functional Analysis (CFA). A formalized training program will be developed and implemented for each individual resident.

3. Data collected through formalized training programs or other activities will be analyzed each quarter by the Program Coordinator and/or the Program Director to determine the appropriateness of the plan for each individual. Additionally, more thorough data will be entered on each fire drill report in order to more accurately track each resident's skills and abilities.
4. Harrison ICF-IID DSPIs and the Program Coordinator will continue to monitor and record data collected during fire and evacuation drills on an on-going basis. This will be done in order to ensure the maintenance of acquired skills for each individual residing within the facility.
5. Completion date: 10-1-2020

W 449

1. The Program Director and Program Coordinator will develop a more detailed evacuation drill procedure and form used to record data during and after the actual evacuation drill. This additional information and a more in-depth analysis will assist in identifying issues that may be peculiar to those identified individuals (Individual #1 and the two who were in quarantine), and thus assist in training both individuals and direct support staff.
2. The facility will, additionally, collect data on other residents who may have difficulties with evacuation drills or who are unable to evacuate. As each resident within the facility requires full assistance and total care in all areas of daily living, and are unable to identify the sound of the alarm or the prompt to evacuate, each individual will be considered at risk and to be in need training and other interventions, which will be added to each annual plan.
3. The Program Coordinator and the Program Director will review all information on the monthly evacuation drill forms to determine risks that still may exist, and review performance data for each as recorded in his/her ISP on a quarterly basis or as becomes necessary following review of the evacuation drills data. The quarterly report will be signed by the Program Coordinator and the Program Director.
4. Continued monitoring will be done by the Program Coordinator and the Program Director through analysis of the regular drills and all other documentation each month to ensure continued compliance.
5. Completion date: 10-1-2020

Harrison ICF-IID

E Tags

E 004

1. Failure to have completed an annual review of the facility's Emergency Evacuation Plan (EEP) to ensure that it continues to provide protective guidelines for all of the individuals in the residence could cause harm to each resident, and could adversely affect the facility as a whole.
2. The Harrison ICF-IID Program Coordinator will determine which of the individuals residing within the facility are at risk for injury or death in an emergency by completing a Risk Assessment (including a Fall Risk Assessment) and a Comprehensive Functional assessment annually or whenever an individual's mental or physical status changes. Additionally, each individual's evacuation rating as determined by the State Fire Marshall's Office will be taken into consideration.
3. Each individual determined to be at risk will have an outcome added to his/her annual plan that addresses any specific area(s) of difficulty in responding to emergency situations, such as fire drills. Data will be collected and reviewed as part of each individual's quarterly review in order to determine current skills levels and abilities. This will be done by the Program Coordinator and the Program Director. Additionally, each individual will participate in monthly evacuation drills, and data will be collected.
4. The facility's Program Coordinator will develop a recording system that will maintain data on all trainings, drills, progress on individual outcomes, and required dates (for training, etc.) to ensure continued compliance with the corrections made to deficient practices. It will also include notes on contacts, discussions, meetings, etc., and updated copies of any information gathered from other emergency agencies. This information will be maintain in the facility's Emergency Information and Policies book.
5. Completion date: 10-4-2020

E 006

1. Harrison ICF-IID will maintain an all-hazards Emergency Plan that is based on facility- and community- based risks, including missing residents, and strategies to address these identified emergencies. This will be reviewed annually by the Program Director, and will be updated as needed in order to afford the highest level of protection and safety for each of the residents residing within the facility.
2. As each individual currently residing within the facility is fully dependent upon the facility safe for their total care, including remaining safe in all situations, development and continued maintenance of emergency plans is critical. The needs of each will be determined by the use of a Comprehensive Functional Assessment, the rating assigned by the State Fire Marshall's representative, and analysis of routine monthly evacuation drill performance.
3. The emergency policies and procedures will be reviewed at least annually, with an updated Risk Assessment for completed at that time. Review of the policies and procedures will also

include any information/analysis gathered during evacuation drills and tabletop exercises, as well as any community- or facility-based emergencies that may have occurred since the preceding review. Additionally, following an actual emergency event, the policies and procedures may be revised as needed.

4. The Program Coordinator will ensure that all policies and plans are reviewed at least annually by maintaining a spreadsheet to track required dates.
5. Date of Completion: 10-4-2020

E 009

1. As each individual currently residing within the facility has been identified through annual CFAs and risk assessments as having the need for total care and assistance, it is imperative that appropriate EPP plans are in place. Harrison ICF-IID will develop all emergency policies and plans with cooperation with local emergency services agencies. The Program Coordinator will develop a working relationship with these agencies and work closely with them to develop and maintain appropriate plans and protocols for dealing with community-based emergencies. In addition, the Program Coordinator and other staff members as appropriate should seek out opportunities to participate in community disaster planning, and to take an active part in any community-based drills that may take place. In the past, attempts to contact /call the agency staff have not been successful; any attempts at contacting will be recorded within the facility's EPP records.
2. Individuals who are at risk from this deficient practice include all those currently residing in the facility; this is based on annually completed risk assessments and Comprehensive Functional Assessments. Upon the admission of any new resident, these assessments will be completed within the first week of residency in order to assess the levels of safety needs.
3. Dates for the annual review of policies will be maintained on a spreadsheet by the Program Coordinator in order to ensure that all policies are within review compliance.
4. The facility will ensure that sustained compliance occurs by regular reviews and updating of the policies as necessary and by tracking continued contact with local emergency groups.
5. Date of completion: 10-4-2020

E 013

1. The individuals currently residing with Harrison ICF-IID have all be found through completed Comprehensive Assessments to require total care and assistance in all areas of living, including safety. In order to provide the highest level of safety to the individuals, it remains imperative that all policies and procedures developed for protecting them in both facility and community emergencies remain updated through annual reviews of each policy by the Program Coordinator or the Program Director.
2. Comprehensive annual assessments are completed annually for each facility resident as part of his/her annual review, and any changes in needs will be accommodated by revisions to emergency policies. Additionally, any new admissions will have a CFA and risk assessments completed within ten days of admission.

3. Annual review and modification of the EEP will be completed by the Program Coordinator or Program Director, with dates for these reviews maintained on a spreadsheet designed for this purpose.
4. Review of the efficacy of all procedures and policies will be maintained through ongoing documentation and close monitoring by the Program Director or QA personnel.
5. Completion date: 10-4-2020

W 024

1. Harrison ICF-IID will develop and maintain a policy regarding the use of volunteers in an emergency situation. As the individuals currently residing within the facility have all been assessed to need total assistance in all areas of daily living, it is critically important to maintain policies regarding the use of volunteers in true emergency events, whether they occur with the building, the community, or during a community-wide emergency event.
2. Resident needs will be assessed annually by completion of a Comprehensive Functional Assessment and a completed risk assessment. Any changes in status will be addressed with revisions to the emergency policies and procedures. Any new admission to the facility will have these assessments completed within 10 days to determine skills and abilities.
3. The policy will be reviewed at least annually and updated as needed. The dates of review will be tracked on a spreadsheet designed specifically for this purpose and maintained by the Program Coordinator.
4. Review of the policies will be monitored by the Program Coordinator, the Program Director, and QA personnel in order to sustain compliance.
5. Completion date: 10-4-2020

W 026

1. The facility will develop policies and procedures to ensure that there is a continuity of all prescribed services for each individual residing within the facility if full evacuation of Harrison ICF-IID becomes necessary during an emergency. This is provided under the 1135 Waiver regarding relocation of care and services during an emergency event to an alternate site.
2. It is imperative to each individual currently residing within the facility to have the same level of care and services he/she currently receives in the event of a relocation to prevent health and safety issues; in addition, the continuation of normal routines will help reduce anxiety resulting from the relocation.
3. The policies and procedures will be reviewed annually by the Program Coordinator, as well as a annual check of all supplies, including food, water, emergency medical supplies, beds and bedding, and any adaptive equipment that each individual might be in need of, to ensure that the supplies are all intact, in good repair, and within current use-by dates.
4. The Program Coordinator will maintain dates of reviews on a spreadsheet developed specifically for this particular purpose as well as dated reviews of necessary evacuation supplies.

5. Completion date: October 10, 2020

E 029

1. The facility will develop and maintain a policy for communication during an emergency situation. The communication plan will include a chain of command policy regarding who will contact whom within the program's administration, as well as family members or legal guardians of each individual. The list will also include contact information for each person named. There will also be a list of all Emergency local and State agencies that must be contacted, as well as well as governing agencies such as the Virginia Department of Health and DBHDS; this list should also contain names and contact information, and designate who will be calling whom.
2. As all individuals currently residing within the facility have been identified via annual assessments to require total care and assistance during emergency situations, it is imperative that safety needs are met. Ensuring that contact information for all involved parties is a critical part of meeting safety and care needs.
3. The Program Coordinator will ensure that the communication plan's list remains current, with changes made as needed (both names and/or telephone numbers) and that the policy/plans are reviewed at least annually.
4. The Program Coordinator will ensure that annual review dates are met by the use of a tracking spreadsheet developed specifically for this purpose.
5. Completion date: 10-4-2020

E 30

1. The facility will develop and maintain a policy for communication during an emergency situation, and the communication plan will include a chain of command policy regarding who will be responsible for contacting whom within the program's administration, as well as family members or legal guardians of each individual. The list will also include contact information for each person named. There will also be a list of all State and local emergency agencies that must be contacted, as well as governing agencies such as the Virginia Department of Health and DBHDS; this list will also contain names and contact information, and designate who will be calling whom.
2. As individuals currently residing within the facility have all been identified via annual assessments to require total care and assistance during emergency situations, it is imperative that safety needs are all met. Ensuring that contact information for all involved parties is a critical part of meeting care and safety needs during times of emergency.
3. The Program Coordinator will ensure that the communication plan's list remains current, with changes made as needed (both names and telephone numbers) and that the policy/plans are reviewed at least annually.
4. The Program Coordinator will ensure that annual review dates are met by the use of a spreadsheet developed specifically for this purpose.
5. Completion date: 10-4-2020

E 031

1. Harrison ICF-IID will ensure that current list of all necessary contact information for Federal, State, and local emergency preparedness staff as well as any other sources of emergency assistance, and the State Licsensing and Certification Agency and the State Protection and Advocacy Agency are maintained within the EPP. This information will include contacts and telephone numbers to be used during emergency situations.
2. As the individuals currently residing within the facility have all been identified via annual assessments to require total care and assistance during emergency situations, it imperative that all safety needs are met. Ensuring that contact information for all involved agencies is a critical part of meeting care and safety needs during times of emergency.
3. The Program Coordinator will ensure that the communication plan's list remains current, with changes made as needed (both names and telephone numbers) and that the policy/plans are reviewed at least annually.
4. The Program Coordinator will ensure that annual review dates are met by the use of a spreadsheet developed specifically for this purpose.
5. Completion date: 10-4-2020

E 039

1. The facility will prepare and follow prescribed training situations for staff and individuals to ensure practice and awareness of emergency procedures and methods that would be necessary in an actual emergency situation, whether it occur within the facility or in the community, or is a community-wide emergency. There will be two tests of the facility's EPP each year, and will consist of participation in a community-wide training exercise, an actual emergency experienced by the facility that requires use of Harrison ICF-IID's EPP, a mock disaster drill, or a table top exercise conducted with facility staff.
2. As the individuals residing within the facility have all been identified via annual assessments to require total care and assistance during emergency situations, it is imperative that all safety needs are met. Having DSPs who have been trained by participating in drills that require critical thinking as well as actual hands-on evacuation or protection will assure the individuals that emergency needs can be met as needed.
3. The Program Coordinator will schedule and conduct a minimum of two drills annually, or arrange participation in community-wide drills if available. All data collected by staff members during each drill, including a group analysis (Hot Wash) of the process, and recommendations for any changes that should be made to make the process more effective or safer for everyone. This data will be maintained within the EPP files, and used as necessary to revise the facility's Emergency Preparedness Plan.
4. Dates of training exercises will be maintained by the Program Coordinator on the spreadsheet specifically designed to monitor review dates for all emergency policies and procedures.
5. Completion date: 10-4-2020

Jane M Sellers, Dir, QDDP
10-4-2020